

**Preventing suicide**  
**A resource for establishing a crisis line**



**World Health  
Organization**

© World Health Organization 2018

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization.

**Suggested citation.** Preventing suicide: a resource for establishing a crisis line. Geneva: World Health Organization; 2018 (WHO/MSD/MER/18.4). Licence: CC BY-NC-SA 3.0 IGO.

**Cataloguing-in-Publication (CIP) data.** CIP data are available at <http://apps.who.int/iris>.

**Sales, rights and licensing.** To purchase WHO publications, see <http://apps.who.int/bookorders>. To submit requests for commercial use and queries on rights and licensing, see <http://www.who.int/about/licensing>.

**Third-party materials.** If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

**General disclaimers.** The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

# Contents

<b>Foreword</b> .....	iv
<b>Introduction</b> .....	1
What are crisis lines? .....	1
<b>The importance of crisis lines for suicide prevention</b> .....	2
Crisis line service delivery .....	3
Crisis line callers .....	5
<b>Establishing a crisis line</b> .....	7
First steps .....	7
Fundraising .....	9
Ethical standards and guidelines .....	10
Governance and compliance with legal requirements .....	11
Call management .....	11
Referral of callers to other service providers .....	12
Follow-up of callers .....	13
Staff and volunteers .....	14
Recruitment of crisis line workers .....	15
Training .....	15
Supervision .....	17
<b>Quality assurance and sustainability</b> .....	18
<b>References</b> .....	19
<b>Annex 1. A short history of crisis lines</b> .....	22
<b>Annex 2. Example checklist of practice tools</b> .....	23
<b>Annex 3. Example of best practice standards within a quality framework</b> .....	24

## Foreword

Suicide is a serious global public health problem that demands our attention yet preventing suicide is no easy task. Current research indicates that the prevention of suicide, while feasible, involves a series of activities ranging from provision of the best possible conditions for bringing up our children and young people, through accurate and timely assessment of mental disorders and their effective treatment, to the environmental control of risk factors. Appropriate dissemination of information and awareness-raising are essential elements for the success of suicide prevention. Cultural, age- and gender-related variations need to be taken into account in all these activities.

In 1999 the World Health Organization (WHO) launched its worldwide initiative for the prevention of suicide. This booklet is one of a series of resources addressed to specific social and professional groups that are particularly relevant to the prevention of suicide. The booklet represents a link in a long and diversified chain that involves a wide range of people and groups, including health professionals, educators, social agencies, governments, legislators, social communicators, law enforcers, families and communities.

We are particularly indebted to Professor Diego de Leo, Australian Institute for Suicide Research and Prevention, Griffith University, Australia; Professor Brian Mishara, Crise, University of Quebec, Montreal, Canada; Dr Gillian Murphy, National Suicide Prevention Lifeline, United States of America; Mrs Dawn O'Neil, Collective Impact, Australia; Mrs Mary Parsissons, Lifeline International, Australia; Dr Diana Rucli, IFOTES, Italy; and Mr Alan Woodward, Lifeline Australia, who produced the first version of this booklet.

The text was subsequently reviewed by the following experts, to whom we are grateful: Professor Ella Arensman, National Suicide Research Foundation, Cork, Ireland; Mrs Marlys Bueber, Shanghai Mental Health Center, Shanghai, China; Dr Kairi Kolves, Australian Institute for Suicide Research and Prevention, Griffith University, Australia; Dr Elise Paul, Leipzig University Hospital, Germany; Dr Morton Silverman, University of Chicago, Chicago, United States of America; Professor Jean-Pierre Soubrier, Centre Ressources en Suicidologie, Paris, France; Dr Yongsheng Tong, Beijing Suicide Research and Prevention Center, Hui Long Guan Hospital, Beijing, China; Dr Lakshmi Vijayakumar, SNEHA, Chennai, India.

We also thank Mr David Bramley, Switzerland for editing, and Mr Yusuke Nakazawa, Japan for graphics design and layout. The collaboration of the International Association for Suicide Prevention (IASP) with WHO on its activities related with suicide prevention is greatly appreciated. This resource is being disseminated widely in the hope that it will be translated and adapted to local conditions which is a prerequisite for its effectiveness.

Dr Alexandra Fleischmann  
*Department of Mental Health and Substance Abuse*  
*World Health Organization*

# Introduction

Improved community detection, intervention in and management of suicidal behaviour are critical to preventing suicide. Crisis lines emerged in the 1950s with the advent of the home telephone in high-income countries and are now available in almost all countries of the world in one form or another (see Annex 1 for a short history of crisis lines). The telephone was seen as an attractive channel for providing intervention services because it was accessible to many, allowed a more private conversation than would occur face-to-face and covered many locations. Since then, crisis lines have proliferated throughout Africa, the Americas, Asia and Europe. In lower-resourced countries, crisis lines are sometimes the only agencies working on suicide prevention. It is estimated that there are over 1000 crisis lines worldwide.

## What are crisis lines?

Crisis lines typically provide services to people in the community and particularly to persons at risk of suicide or thinking about suicide. Crisis lines offer non-judgemental and confidential emotional support in times of personal crisis when individuals may feel unable to cope with the challenges in their lives.

Crisis lines originally provided services over the telephone, with some – such as the Samaritans in the United Kingdom – also providing face-to-face listening and help. Crisis lines are often referred to as helplines, telephone counselling services, hotlines, distress lines and telephone emergency services. In recent years there has been a rapid expansion of services using new technologies (Mishara & Kerkhof, 2013), mostly using Internet chat services and text messaging interactions from mobile telephones. For the purpose of this booklet, all of these services are included in the broad term “crisis lines” and all persons seeking contact through any channel are referred to as “callers”.

## **The importance of crisis lines for suicide prevention**

People's need for regular contact and caring is ideally met by other people around them, such as parents, siblings, friends, teachers and colleagues. However, some people, because of geographical or other types of isolation such as chronic physical or mental illness, may neither have opportunities for interaction nor receive the caring connections or feelings of belonging that they need to maintain a desire to live. Crisis lines help alleviate the distress a person may be experiencing and can reduce the intensity of such feelings to enable problem-solving and practical actions to be considered in response to personal problems.

Many persons who are suicidal do not seek help from face-to-face health services or support from friends or family members. Some receive mental health care from a professional but have never spoken about suicidal thoughts. The confidential services offered by crisis lines may help overcome the barrier of stigma surrounding suicide and mental health problems that could prevent a person from seeking help in other ways. Consequently, crisis lines often engage with persons who are not otherwise receiving help for their suicidal thoughts.

In most cases it is difficult to measure the effectiveness of crisis lines in preventing suicide because of the anonymous nature of interactions with callers and the relatively short and generally single-service sessions without follow-up or continuity. However, some research provides encouraging results. A major study of the outcomes achieved for telephone callers to a crisis line in the USA found that intent to die was reduced by the end of the call (Gould et al., 2007). A study in Australia that examined telephone callers to a youth crisis line also found measurable reductions in suicidal ideation during the call (King et al., 2003). A recent study in the United Kingdom found a telephone crisis line was effective in reducing suicidal and self-harm ideation with callers (Tyson et al., 2016).

National suicide prevention strategies often include crisis lines as one component to help people in distress in an accessible and immediate way, regardless of geographical barriers. Alongside mental health promotion, prevention and treatment of mental and substance use disorders and other interventions for the prevention of suicide, crisis lines play an important complementary role.

## Crisis line service delivery

A core characteristic of crisis lines is to provide compassionate, non-judgemental, empathetic and respectful listening to anyone who calls. Some crisis line services that focus on suicide prevention adopt a more structured collaborative problem-solving approach in which the crisis line worker assesses suicide risk by asking questions and explores options that orient the conversation towards motivating the caller to action.

Others crisis lines emphasize **emotional support and non-judgemental listening**. This allows callers to explore the issues in their lives in an environment that provides emotional support, and hence empowers them to themselves identify what they would like to do.

The **emotional support and connection** provided by the workers of crisis lines are key elements of the service delivery model. The ability to connect with a caller, as well as to show empathy and respect in order to strengthen the caller's sense of belonging, have been shown to be key qualities and competencies in a crisis line worker, as part of a process which may reduce suicide risk (Mishara et al., 2007b).

Crisis lines are typically provided free of charge or for the cost of a local call through accessible technologies such as the telephone or through new media such as email, online chats, text messages or social media platforms. Crisis lines have the goal of operating 24 hours a day, 365 days a year, although the times when services are available can vary depending on capacity.

Most crisis line services have a service delivery model that ensures that the service:

- is provided free of charge (or the caller pays only the cost of a local telephone call);
- is staffed by trained volunteers, paid mental health professionals, or paid paraprofessionals (trained or accredited to a standard but not registered with professional bodies) full-time or part-time;
- is anonymous – i.e. a name/personal identification is not necessary to receive the service (although some crisis lines identify callers by a name or pseudonym to ensure continuity when the caller or crisis line worker calls back);
- is confidential (except in emergency situations where there are safety concerns<sup>1</sup>);

---

<sup>1</sup> Note: Not all crisis lines intervene during an emergency such as a suicide in progress. Some do not intervene for ideological reasons; others cannot intervene because of the lack of available emergency services in some parts of the world (see Mishara & Weisstub, 2010).

- in most cases, considers each call as a single session with no fixed time limit;
- in some cases, includes a follow-up call to check on safety and well-being;
- is non-judgemental;
- offers emotional support and connection;
- is non-discriminatory – i.e. no religious, political or ideological requirements are needed to receive help and no religious, political or ideological beliefs are communicated to callers;
- provides routine safety checks and identification of suicidal ideation and the level of suicide risk routinely on all calls, with crisis intervention techniques applied as appropriate;
- has workers who are trained and supervised to ensure their competency to perform their work;
- provides advice for referral to other resources, when appropriate;
- in some cases, offers a translation service and access for persons with hearing difficulties or other disabilities.

Crisis lines may also be complemented by other services, such as:

- drop-in centres that provide face-to-face help;
- outreach programmes in communities to provide face-to-face help;
- websites (e.g. for access to self-help or other information online);
- responses to text messages, emails, online chats, discussion forums, SMS text messages;
- self-help and other information in different formats (e.g. leaflets, videos, CDs, DVDs, online self-help programmes);
- post-disaster support in response to natural disasters such as hurricanes, flooding or earthquakes;
- outreach programmes in communities to provide education and training about suicide prevention and mental health to community gatekeepers (e.g. general practitioners, health workers, family workers, school teachers, police, fire fighters);
- information about their services at suicide “hotspots” – i.e. locations where suicidal acts happen frequently (e.g. railway stations, bridges, cliffs) – usually with signs or posters;



- help and support to persons bereaved by suicide (often called “survivors”), often in group sessions;
- information and support to persons who know someone who is suicidal or who has attempted suicide;
- advocacy to governments to develop suicide prevention strategies and programmes.

## Crisis line callers

Reports from crisis lines indicate that numerous circumstances and experiences precede a contact. However, the overall underlying motive appears to be the need to connect safely with another person for help and support in a crisis situation or to meet a general emotional need.

Most crisis lines attract people of all ages, with the highest numbers of telephone contacts in the 25–55-year age group, and chat and text calls being from persons younger than age 18 years (Callahan & Inckle, 2012; Drexler, 2013; Murphy, 2013). Some studies have found that females call crisis lines more often than males do (Gould et al., 2018; Mishara & Diagle, 2001).

Crisis lines respond to a wide range of issues. For example, data collected by Australian crisis line workers showed that the issues most frequently cited by callers were family and relationships (43.6%), health and disability (36.2%) and the sense of self in the community (32.7%) (Lifeline Australia, 2009). Data collected on callers to Samaritans hotlines indicate similar themes, with the most common reasons for contacting the crisis line being mental health problems (13.2%), self-harm (12.3%), relationship breakdown (7.6%), relationship problems (6.8%) and family problems (6.5%) (Pollock et al., 2010).

Many callers indicate that the reason for their call to a crisis line is due to **emotional, psychological, or physical turmoil** in their daily lives. Some callers do not know who else to turn to and are socially isolated. For others, a specific crisis motivates them to call. Many telephone calls are received during periods of significant life challenges such as relationship breakdown, burdens associated with raising children, caring for others (such as elderly parents), work loss, other work-related issues, or a financial crisis (Lifeline Australia, 2009).

Mental health issues are experienced by many of those who call crisis lines. An Australian study found anxiety and depression to be highly represented in the profile of callers (Burgess et al., 2008). A North American study found that 25% of calls were from persons who disclosed that they were receiving treatment from mental health services (Gould et al., 2012).

Various studies have shown that suicidal individuals do actually call crisis lines (Litman, 1970; Sawyer, Sudak, & Hall, 1972). An examination by Mishara et al. (2007a) found that 35.2% of calls made to crisis lines in the USA were from persons in suicidal crisis. In Australia, a study of callers to Lifeline found that 29% replied affirmatively to the question: “Do you currently have thoughts about harming yourself or not wanting to be alive?” (Perkins & Fanaian, 2004). In a detailed examination of callers to crisis lines in the USA, over half of these callers had a suicide plan at the time of the call, 8% had taken some action to harm or kill themselves immediately prior to the call, and nearly 60% had made previous suicide attempts (Gould et al., 2007).

Some people contact a helpline immediately before they intend to attempt suicide or after they have initiated a suicide attempt, such as after having ingested pills or while standing on a balcony and considering jumping. Although these high-risk calls are infrequent, helpers receive specific training on how to respond to them since they occur with all crisis lines.

Crisis services are increasingly provided through **multiple contact channels**, such as email, online chats, text messages or social media platforms. Compared to telephone calls, **chat and text message contacts** tend, on average, to concern serious crises such as eating disorders, self-mutilation and sexual aggression (Sefi & Hanley, 2012). Contacts by Internet chat and text messages tend more frequently to concern suicide and, overall, people who make this kind of contact are at higher suicide risk than those who make contact by telephone.

When **chat and text help** is available, these services generally attract large numbers of contacts – **particularly adolescents and young adults**. Users of chat and text services tend to be younger than telephone callers, their level of emotional distress tends to be greater, and a higher proportion have suicidal intentions and plans (Callahan & Inkle, 2012; Drexler, 2013; Murphy, 2013; Sefi & Hanley, 2012). Those who use chat and text services do not generally use telephone help services (Fukkink & Hermanns, 2009; Meunier, 2011). This suggests that chat and text services attract people who are in need of help, but many of these persons do not use telephone helpline services or consult with mental health professionals.

## **Establishing a crisis line**

Crisis lines typically operate as self-regulated, community-based nongovernmental services. Although they are often one programme within a crisis or suicide prevention centre that also offers other services, in some settings they may be the only suicide prevention service available. The formation of a board of directors or core steering group consisting of a mix of professionals (e.g. lawyers, health professionals, accountants) and other nongovernmental organizations may be helpful.

### **First steps**

Crisis lines often emerge through the actions of groups of interested people from a community who identify a need for a crisis line, sometimes in response to a community crisis or high incidence of suicide. This community connection is an important feature of crisis lines and supports their ability to offer help in ways that will be appealing to callers. Often, it is one highly motivated community member who organizes the establishment of a crisis line and is the driving force behind it. Establishing or using an already existing checklist (e.g. <https://www.befrienders.org/file/helpline-checklist-pdf>) may be useful in the early stages of setting up a crisis line.

Before establishing a crisis line, the following decisions need to be made:

- 1. Determination of the primary focus.** Although many crisis lines focus primarily on suicide prevention, some advertise themselves as being available to talk to anyone seeking help for a personal problem. Usually, crisis lines express their primary focus in their choice of name and in the advertising and marketing of their services. For instance, the choice of a name such as Suicide Prevention Helpline communicates clearly that the focus is on helping people who are suicidal. A name such as Friends Helpline does not communicate a specific focus on suicide prevention. Some crisis lines choose to focus on young people, calling themselves, for instance, Youth Helpline.
- 2. Affiliation or not with existing crisis lines.** A new crisis line may choose to affiliate with a national or international network of crisis lines that provide training materials and support in establishing a new line. All international networks have criteria for membership, which may include obligations in terms of the quality of services, amount and type of training and supervision, and adherence to ethical standards. Although some crisis lines may choose not to affiliate with an existing network or international organization, anyone considering establishing a crisis line may find it useful to examine the practices of different crisis lines that are already operational. When new crisis lines are established, they often affiliate with a larger or international network of crisis lines – such as Befrienders Worldwide (<http://www.befrienders.org>), the International Federation of Telephone Emergency Services (<http://www.ifotes.org>), and LifeLine International (<https://www.lifeline.org.au>) – which can help them establish a national or local crisis line and can provide training material, standards, guidelines and support.
- 3. Service delivery model.** Crisis lines vary as to whether or not they intervene when a suicide attempt is imminent (Mishara & Weisstub, 2010). Basically, there are two approaches to providing help over the telephone or the Internet. The first is nondirective listening (inspired by the psychotherapy approach of Carl Rogers [1957]), and the other combines active listening with a more direct problem-solving approach (based on crisis theory, solution-focused therapy techniques or collaborative problem-solving). Collaborative problem-solving, for instance, may include emergency interventions in crisis situations and proactive follow-up and referrals to community and mental health services. Recent research has shown that callers in a suicidal crisis can benefit from an approach that focuses more on problem-solving within the context of respectful empathetic listening rather than an approach involving only active listening (Mishara et al., 2007a; 2007b).

# Fundraising

Raising funds to support the day-to-day costs of operating the service is a key element in starting and sustaining a crisis line. Experience has shown that services may spend one or more years fundraising and preparing a funding model that will sustain service operations over time. During this preparatory phase, consideration needs to be given to governance, recruitment, training, development of practice tools and guidelines, quality assurance, and building of local relationships with other service providers. Planning, budgeting and sustainable funding are needed to ensure the long-term success of a crisis line.

A crisis line can receive funding from a variety of sources, such as:

- personal donations;
- philanthropic organizations;
- government funding;
- support from religious entities;
- communication and information technology providers;
- social enterprises (e.g. sales from second-hand goods);
- community-based fundraising (e.g. from community events);
- in-kind support (e.g. time or infrastructure, such as a building to operate from, or donated telephone and internet services).

When fundraising, some of the costs of a crisis line to consider are:

- premises that provide a safe and secure place for workers to operate and that can be safely accessed 24 hours a day, 7 days a week;
- implementation of an initial training programme, refresher training sessions and upskilling;
- legal registration costs (including obtaining charitable or nonprofit organization status);
- liability or other insurance costs, if deemed necessary;
- installation of telephones and other technology (e.g. computers and software), as well as ongoing costs;

- costs for telephone calls and Internet access;
- advertising for the crisis line;
- provision of refreshments for workers and associated infrastructure (e.g. coffee machine, refrigerator);
- supervision of workers;
- full-time or part-time paid staff.

## Ethical standards and guidelines

Crisis lines should be available to everyone in the community. It is imperative that callers are responded to with full respect for diversity and that callers encounter no form of discrimination or pressure to conform to a particular political, religious or social belief system.

An understanding of, and a commitment to, human rights is integral to the ethical standards which crisis lines follow. These standards are based on fundamental principles such as nondiscrimination, respect for callers, and political and religious neutrality. Crisis lines should have a document outlining their ethical standards that is provided to all workers and is discussed as part of their training. This document should specify the limits of workers' involvement as well as their obligations concerning respect for callers and maintenance of confidentiality.

The ethical standards generally include prohibitions on:

- meeting callers privately or exchanging personal information;
- discussing calls with relatives and friends;
- telling callers to follow a specific religious practice.

It should be made clear to all workers that failure to respect the ethical standards of the crisis line will not be tolerated and that anyone who is not able to conform to those standards cannot continue to be involved with the service.

## Governance and compliance with legal requirements

Depending on local rules about the receipt of funds and delivery of services to a community, crisis lines may be operated by a charity, an association, a company or another type of entity.

In view of the complexity of the needs of callers, it is appropriate for crisis lines to be operated within legal entities that are formally registered and that comply with ethical standards. It is a key consideration of governance to ensure that the crisis line operates within a structure that complies with the laws of the country in which it operates.

Depending on the laws of the country, it is important to consider what the compliance requirements will be for the crisis line. For instance, it is important to comply with workplace laws for the engagement of workers, as well as occupational health and safety standards, and company management or tax laws that relate to fundraising. It is crucial to obtain professional advice on these issues to ensure compliance with legal requirements when establishing a crisis line.

Most crisis lines have a governing board of directors or equivalent which represents the interests of the service and provides guidance and support for establishing and operating the crisis line. The skills and experience of these persons must be appropriate to their role which is vital to the crisis line's success, including its sustainability and ensuring that it offers a high-quality service.

## Call management

A key consideration is to maximize callers' access to the crisis line at their time of need.

Some crisis lines operate according to regular business hours (e.g. 09:00 to 17:00). For those that operate 24 hours a day, 7 days a week, it can be a challenge to organize personnel and operations to ensure they are available during the night and early morning. However, this access to service at all times is a feature that distinguishes crisis lines from most other community and health services.

In order to manage calls, techniques such as phone queues or automated call routing are sometimes used to ensure the shortest waiting time for callers. Choosing the right technology will depend very much on the size of the population to be served and the

funds available. Also, a system to monitor the number of calls should be put in place to help in planning and evaluation of the service.

In general, the first available worker handles the call, and callers are discouraged from continued contact with the same worker. This is usually justified by the fact that the crisis line is always available but a specific individual may not be available at a time of need.

## Referral of callers to other service providers

Crisis line workers often refer callers to other service providers and usually work closely with emergency services such as police, ambulance, mental health services and hospitals. They generally view themselves as part of a community's collaborative support network that ensures the safety and emotional well-being of any person in emotional or psychological distress.

Depending on local conditions, agreements may be established with the following:

- police;
- fire service;
- ambulance services;
- hospitals;
- mental health services;
- general practitioners and other health and social workers;
- private medical clinics;
- traditional healers;
- domestic violence services;
- rape crisis services;
- services for lesbian, gay, bisexual, transsexual and intersex (LGBTI) persons;
- women's organizations or centres;
- youth organizations;



- organizations working to help people with HIV/AIDS;
- emergency accommodation services;
- city, town and village leaders, and municipal and local governments;
- religious bodies;
- schools;
- prisons;
- the military;
- transport services (e.g. rail organizations).

## Follow-up of callers

Follow-up contact with suicidal persons is an important element of many national suicide prevention strategies. Although most crisis lines have not historically conducted follow-up calls to callers, recent initiatives suggest that follow-up calls are both feasible and successful in preventing further suicidal behaviour.

All suicidal callers to the Psychological Crisis hotline in Beijing, China, for instance, are asked if they would like to receive a follow-up call after 12 months. Approximately 80% of callers accept this follow-up. Suicidal callers who are deemed at especially high risk are asked to provide the telephone number of someone who could be called by hotline staff to inform the third party of the high-risk situation. While the caller is kept on the phone, another crisis line worker calls the third party to enlist their support. More than 80% of high-risk callers provide this information.

One recent study of 550 suicidal callers to the National Suicide Prevention Lifeline in the USA found that the majority of individuals who had received follow-up calls reported that the call had played a significant role in preventing them from killing themselves (53.8%) and in keeping them safe (59.6%) (Gould et al., 2018).

## Staff and volunteers

Many crisis lines begin as small community organizations with few personnel. Crisis line workers are often volunteers who also provide administrative assistance and carry out community outreach and fundraising.

In addition to volunteers, some crisis lines also decide to have paid staff who may include mental health professionals. Paid staff may be helpful late at night and may provide administrative functions or deliver training.

To support the operation of a crisis line, personnel are needed to handle the following tasks (with one person often being responsible for multiple tasks, according to what is feasible in the local context):

- crisis line manager;
- crisis line supervisor for workers;
- roster or scheduling coordinator;
- training coordinator;
- fundraising coordinator;
- personnel for administrative functions;
- community liaison person(s);
- webmaster and website development;
- marketing and promotion coordinator;
- monitoring and evaluation.

## Recruitment of crisis line workers

The recruitment of crisis line workers may involve an extensive process of screening and interviews to select persons who can effectively connect with callers, provide a non-judgemental, empathic response, and learn essential techniques such as suicide risk assessment and collaborative problem-solving. Crisis lines that put less emphasis on screening often find that workers drop out or are deemed not suitable for the task during training. The advantage of more extensive screening before training is that potential workers who are not suitable do not proceed further in the recruitment process, and training is provided only to persons who are identified as likely to perform well in the delivery of the service.

## Training

Training is a very important feature of crisis lines worldwide, regardless of whether the workers are paid or volunteers. Standard training programmes are available from national and international crisis lines and networks and may need to be adapted to the local context. Training generally involves practice in non-judgemental listening skills, learning to ask about suicidal thoughts, plans and attempts, risk assessment, and specific methods for helping callers. Initial training generally involves repeated practice in role-play situations and usually lasts for at least 20 hours.

Different types of training for crisis line workers have been compared. In a study in the USA, callers who had spoken with crisis line counsellors trained in Applied Suicide Intervention Skills Training (ASIST) were less suicidal, less depressed and more hopeful at the end of the call than callers who spoke with counsellors who had not received ASIST training (Gould et al., 2013).

Training is generally followed by mentoring or supervision. New workers are supported during their initial periods of work by a mentor or supervisor who is with the worker while taking calls and can provide support and feedback to improve the worker's skills. Training should be delivered by professionals, possibly from other organizations.

Key competencies or core skills that most crisis lines would agree on include:

- empathic listening;
- ability to be non-judgemental;
- ability to develop a connection or rapport with the caller;
- ability to talk about suicide and assess suicide risk;
- ability to explore options for problem-solving with the caller when collaborative problem-solving is part of the chosen service delivery model.

Other practical skills have to be learned – such as the technical skills for using the telephone, chat or text message systems; recording of statistics or other caller notes using computerized reporting programmes if available; and handling calls where callers are abusive or behave inappropriately.

Training should include specific information about suicide and its prevention, how best to help suicidal persons in crisis, how to support friends and family members who call about a suicidal person, and how to support persons bereaved by suicide. It is important to include training in how to ask about suicidal ideation, plans and attempts, and how to assess suicide risk. Crisis line workers often acknowledge the need to talk about suicide with callers but may be reluctant to do so if they have not had training with practical exercises.

It is important for crisis line workers to be prepared to answer calls from people who are highly distressed about the circumstances that they are experiencing.

A wide range of further topics may be covered in training sessions (e.g. mental and substance use disorders, family violence, childhood trauma, grief and loss, chronic illness, addictive behaviours). Training also involves familiarizing workers with the procedures and practices of the crisis line in different situations, including when a suicide attempt is in progress during a call. Importantly, crisis line workers need to know about local resources that are available to help callers with specific problems (see Annex 2 for a checklist of practice tools). Crisis lines with more than one means of communicating sometimes have different people respond by telephone, chat and text message, and other trained helpers who respond to more than one type of communication. Generally, workers begin by answering telephone calls and then receive specific supplementary training and supervised practice in responding to chat or text calls.

# Supervision

Supervision is essential to ensure quality in service and adequate support for the well-being of workers. Most crisis lines have explicit supervision policies and procedures. Supervision may also be obtained via an established collaboration with health professionals.

Supervision is best understood as assisting in four main areas:

1. Debriefing and support after a call to help the worker with emotional reactions and difficulties encountered during the call.
2. Provision of feedback to crisis line workers to improve their skills.
3. Assistance with organizational and administrative procedures such as record-keeping and, depending on procedures, follow-up planning or notes for other workers who may receive a call from the same person.
4. Quality control, by ensuring that callers receive appropriate and useful help.

To carry out their role, supervisors usually require a high level of skills, training and experience, including:

- extensive experience on a crisis line and other counselling situations;
- an understanding of techniques for crisis intervention, such as service-specific protocols on contacting police or emergency services when there is imminent risk to the life or safety of a caller or third parties;
- completion of intensive training in supervision processes and related areas, such as the teaching and training skills relevant to supervision;
- demonstrated ability to understand complex crisis issues;
- demonstrated ability to teach and convey worker skills;
- ability to identify strengths and weaknesses in crisis line practice and to actively implement changes (e.g. propose further training);
- ability to act as a mentor to workers;
- ability to stimulate learning and capacity-building (e.g. via train-the-trainer programmes);
- ability to maintain a consistent focus on workers' concerns in order to monitor progress;
- knowledge of the mental health assessment of callers.

## **Quality assurance and sustainability**

While there are no universal international standards for crisis lines, quality assurance and best practice standards are available through the major crisis line networks and, in many countries, as a specific quality framework.

Quality assurance is important for crisis lines because of the open access that they offer to callers and their orientation to crisis which suggests that vulnerable people will be the users of the services. Moreover, suicide prevention functions performed by crisis lines should operate within a standard practice framework for efficacy and safety. Quality assurance should be ongoing and should be linked to monitoring and evaluation.

Standards have been published for suicide risk assessment and response (Joiner et al., 2007) as well as for the imminent risk of suicide, where best practices support a collaborative approach to engagement with callers (Draper et al., 2015). A national quality framework for TeleWeb support services has been developed in Australia through consultation with various crisis lines and related services (<http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-q-quatel>). The United States National Suicide Prevention Lifeline has developed standards and best practice guides on both assessment of risk and responding to callers at imminent risk of suicide (<https://suicidepreventionlifeline.org/best-practices/>). Further examples of best practice standards within a quality framework are provided in Annex 3.

## References

- Burgess N, Christensen H, Leach LS, Farrer L, Griffiths KM. Mental health profile of callers to a telephone counselling service. *J Telemed Telecare*. 2008;14:42–7.
- Callahan A, Inckle K. Cybertherapy or psychobabble? A mixed methods study of online emotional support. *Brit J Guid Couns*. 2012;40:261–78.
- Draper J, Murphy G, Vega E, Covington D, McKeon R. Helping callers to the National Suicide Prevention Lifeline who are at imminent risk of suicide: the importance of active engagement, active rescue and collaboration between crisis and emergency services. *Suicide Life Threat Behav*. 2015;45:261–70.
- Drexler M. Crisis chat: providing chat-based emotional support. In: Mishara B, Kerkhof A, editors. *Suicide prevention and new technologies: evidence based practice*. London: Palgrave Macmillan; 2013:224).
- Fukkink RG, Hermanns JM. Children's experiences with chat support and telephone support. *J Child Psychol Psychiatry*. 2009;50:759–66.
- Gould MS, Cross W, Pisani AR, Munfakh JL, Kleinman M. Impact of Applied Suicide Intervention Skills Training (ASIST) on National Suicide Prevention Lifeline counselor: interventions and suicidal caller outcomes. *Suicide Life Threat Behav*. 2013;43: 676–91.
- Gould MS, Kalafat J, Harrismunfakh JL, Kleinman M. An evaluation of crisis hotline outcomes. Part 2: Suicidal callers. *Suicide Life Threat Behav*. 2007;37:338–52.
- Gould MS, Lake AM, Galfalvy H, Kleinman M, Munfakh JL, Wright J et al. Follow-up with callers to the National Suicide Prevention Lifeline: evaluation of callers' perceptions of care. *Suicide Life Threat Behav*. 2018;48:75–86.
- Gould M, Munfakh J, Kleinman M, Lake A. National Suicide Prevention Lifeline: enhancing mental health care for suicidal individuals and other people in crisis. *Suicide Life Threat Behav*. 2012;42:22–35.
- Joiner T, Kalafat J, Draper J, Stokes H, Knudson M, Berman A et al. Establishing standards for the assessment of suicide risk among callers to the National Suicide Prevention Lifeline. *Suicide Life Threat Behav*. 2007;37:353–64.

King R, Nurcombe B, Bickman L, Hides L, Reid W. Telephone counselling for adolescent suicide prevention: changes in suicidality and mental state from beginning to end of counselling session. *Suicide Life Threat Behav.* 2003;33:400–11.

Lifeline Australia. Crisis support through 13 11 14: A profile of callers. Canberra: Lifeline Australia; 2009.

Litman RE. Suicide prevention center patients: a follow-up study. *Bulletin of Suicidology.* 1970;6–7:358–63.

Meunier P. Un outil jeune pour un public jeune. Brussels: Observatoire social de Télé-Accueil Bruxelles; 2011 (<http://www.sos-amitie-nice.org/upload/Un-outil-jeune-pour-un-public-jeune-ChatAccueil.pdf>, accessed 10 May 2018).

Mishara BL, Chagnon F, Daigle M, Balan B, Raymond S, Marcoux I et al. Comparing models of helper behavior to actual practice in telephone crisis intervention: a silent monitoring study of calls to the U.S. 1-800-SUICIDE network. *Suicide Life Threat Behav.* 2007a;37:293–309.

Mishara BL, Chagnon F, Daigle M, Balan B, Raymond S, Marcoux I et al. Which helper behaviors and intervention styles are related to better short-term outcomes in telephone crisis intervention? Results from a silent monitoring study of calls to the U.S. 1-800-SUICIDE Network. *Suicide Life Threat Behav.* 2007b;37:310–23.

Mishara BL, Daigle M. Helplines and crisis intervention services: challenges for the future. In: Lester D, editor. *Suicide prevention: resources for the millennium.* Philadelphia (PA): Brunner-Routledge; 2001:153–71.

Mishara B, Kerkhof A, editors. *Suicide prevention and new technologies: evidence based practice.* London: Palgrave Macmillan; 2013.

Mishara BL, Weisstub DN. Resolving ethical dilemmas in suicide prevention: the case of telephone helpline rescue policies. *Suicide Life Threat Behav.* 2010;40:159–69.

Murphy G. The National Suicide Prevention Lifeline and new technologies in suicide prevention: crisis chat and social media initiatives. In: Mishara B, Kerkhof A, editors. *Suicide prevention and new technologies: evidence based practice.* London: Palgrave Macmillan; 2013:224.

Perkins D, Fanaian M. *Who calls Lifeline?* Sydney: Centre for Equity and Primary Health Care Research, University of New South Wales; 2004.



Pollock K, Armstrong S, Coveney C, Moore J. An evaluation of the Samaritans telephone and email emotional support service. Nottingham: University of Nottingham; 2010.

Rogers CR. The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*. 1957;21:95–103.

Sawyer JB, Sudak HS, Hall RS. A follow-up study of 53 suicides known to a suicide prevention center. *Suicide Life Threat Behav*. 1972;2:227–38.

Sefi A, Hanley T. Examining the complexities of measuring effectiveness of online counselling for young people using routine evaluation data. *Pastor Care Educ*. 2012; 30:49–64.

Tyson P, Law C, Reed S, Johnsey E, Aruna O, Hall S. Preventing suicide and self-harm: evaluating the efficacy of a helpline from a service user and helpline worker perspective. *Crisis*. 2016;9:353–60.

## **Annex 1. A short history of crisis lines**

One of the earliest crisis line services began in 1953 with the founding of The Samaritans, which soon established branches throughout the United Kingdom of Great Britain and Northern Ireland. In Berlin, Germany, the first crisis line was established in 1956. In the USA, the Los Angeles Suicide Prevention Centre was founded in 1958. It was the first in the country to provide a 24-hour crisis line and used community volunteers to provide its services. A similar service, Lifeline, was established in Australia in 1963 and quickly spread to other parts of the southern hemisphere. The Suicide Assistance Center (El Centro de Asistencia al Suicida) was founded in Buenos Aires, Argentina, in 1967 and is still in operation.

In 2002, the Beijing Psychological Crisis hotline was established and has since accepted more than 300 000 calls. This hotline now regularly answers 100 calls a day with many more received than can be addressed. SOS Amitié is accessible 24 hours a day, seven days a week (including during holidays) and has been serving the people of France for more than 50 years.

In 1995, several major crisis lines began working together to strengthen knowledge-sharing and to increase collaboration between crisis lines globally. In 2008, these networks joined to form a global alliance called the Emotional Support Alliance (ESA), which was renamed as the World Alliance of Crisis Helplines (WACH) in 2013. The vision of the alliance is for people in emotional crisis to be able to access help wherever they are in the world.

## Annex 2. Example checklist of practice tools

This example checklist of practice tools comprises materials that may be useful for workers of a crisis line to have readily available for their guidance and reference:

Ethical standards and practices	
Crisis intervention guidelines	
Methods for actively engaging callers	
Methods for assessing imminent risk of suicide	
Guidelines for engaging emergency services in active rescue when a suicide attempt is in progress or there is imminent risk	
Guidance on when and how to make referrals to other local services (with information about services that are available locally)	
Memoranda of understanding for referrals to emergency services and community resources	
Policies on caller anonymity	
Policies on follow-up calls for callers assessed as being at risk but without emergency intervention taken	
Guidance on when and how to contact a supervisor	
Guidelines for supervisors	
Procedures for obtaining information about overdoses with drugs, poisons, chemicals or other substances (with contact information to poison control centres or online resources)	
Guidelines for assisting someone calling about another person at risk of suicide who may be at imminent risk	
Guidelines for helping persons bereaved by suicide	
Policies concerning frequent callers	
Responses to abusive callers	

### **Annex 3. Example of best practice standards within a quality framework**

To ensure the quality of crisis lines, a quality framework should be developed when the crisis line is established.

1. **Person-centred, lifesaving approach.** The crisis line will demonstrate a life-affirming, person-centred approach to ensure that the safety and well-being of individuals are the focus of their activities.
2. **Service delivery.** The crisis line will provide services that are informed by evidence and are subject to ongoing review.
3. **Volunteers and staff.** Volunteers and staff are valued within the crisis line and demonstrate competence relevant to its objectives.
4. **Accountability.** The crisis line will meet funding, legal, financial, ethical and professional requirements in delivering its services.
5. **Leadership, innovation and governance.** The crisis line will demonstrate leadership and innovation in response to the changing needs of service users, stakeholders and the broader community.
6. **Systems.** The information technology systems used will be accessible, reliable, responsive and secure, and will use adaptable and compatible technologies.
7. **Policies and guidelines.** Written documentation is available to guide staff and volunteers to deliver a high-quality service to people who engage with the crisis line.

